STATE OF SOUTH CAROLINA
DEPARTMENT OF CONSUMER AFFAIRS

PROFESSIONAL EMPLOYER ORGANIZATIONS

S.C. Code Ann. § 40-68-10 et seq.

www.scconsumer.gov

(803) 734-4200

Mailing Address
P.O. Box 5757
Columbia, SC 29250-5246

Street Address
3600 Forest Drive
Columbia, SC 29204-4006

INSURANCE SCHEDULE

(Please type or print in black ink)

PLANS OF INSURANCE OFFERED BY:

Name of PEO or PEO Group		**Date**	

Type of Plan		**Name of Carrier**			
Policy Number		**Effective Date**			
Insurance Agent					
Business Address					
City		**State**		**Zip**	
Telephone Number		**Fax Number**			

Type of Plan		**Name of Carrier**			
Policy Number		**Effective Date**			
Insurance Agent					
Business Address					
City		**State**		**Zip**	
Telephone Number		**Fax Number**			

Type of Plan		**Name of Carrier**			
Policy Number		**Effective Date**			
Insurance Agent					
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Telephone Number		**Fax Number**			

Type of Plan		**Name of Carrier**			
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Telephone Number		Fax Number			

Type of Plan			Name of Carrier		
Policy Number			Effective Date		
Insurance Agent					
Business Address					
City		State		Zip	
Telephone Number		Fax Number			

This list should contain ALL plans offered by the PEO or PEO Group as of the date of filing. South Carolina Code § 40-68-110 requires licensees to notify all client companies and the Department in writing about a discontinuance and replacement of any health or workers' compensation insurance coverage no later than ten (10) business days after the discontinuance and before offering any replacement policy.

RELEASE

I authorize the Department of Consumer Affairs to directly contact any insurance carrier or agent listed above to verify coverage, premium payment status, any disputed premium, and related matters. I hereby authorize each insurance carrier and agent to release the requested information to the Department, and hold them harmless for the release of this information subject to this release authorization. A photocopy of this release shall be as valid as the original.

_____

Signature

_____

Date

_____

Type or Print your Name and Title

SWORN TO AND SUBSCRIBED before me

this _____ day of _____, 20_____

_____ (SEAL)

Notary Public For _____

My Commission Expires:

_____

Do not fax this form. An original, signed and notarized form is required.

The South Carolina Freedom of Information Act may require the Department of Consumer Affairs to release this form as a public record; however personal identifying information will be released only if required by law.